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| <b>Case Number:</b>   | CM15-0083031 |                              |            |
| <b>Date Assigned:</b> | 05/05/2015   | <b>Date of Injury:</b>       | 08/21/2014 |
| <b>Decision Date:</b> | 06/04/2015   | <b>UR Denial Date:</b>       | 04/02/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/30/2015 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 64 year old female sustained an industrial injury to the back on 8/21/14. The injured worker's pain improved with medications and she returned to work. The injured worker had a recurrence of symptoms on 1/7/15. Previous treatment included physical therapy (approximately six sessions) and medications. The injured worker reported poor response to physical therapy. The injured worker reported having some benefit from using an electrical stimulation unit during physical therapy. In a Doctor's First Report of Occupational Injury dated 3/18/15, the injured worker complained of back pain with radiation to lower extremities. Physical exam was remarkable for pelvic unleveling with the left behind the right by one centimeter an increase in the normal lumbar lordotic curvature, tenderness to palpation with muscle guarding over the paraspinal musculature and lumbosacral junction, positive bilateral straight leg raise and decreased sensation in the bilateral L5-S1 distribution. The injured worker ambulated with a left limp using a single point cane. X-rays showed multilevel moderate lumbar spondylosis with a degenerative spur between L4-5 and L5-S1 and retrolisthesis of L3 on L4. Current diagnoses included lumbar spine sprain/strain with bilateral lower extremity radiculitis. The treatment plan included aqua therapy twice a week for four weeks, a home interferential unit and continuing medications (Norco and Ibuprofen).

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Aquatic therapy two (2) times per week for four (4) weeks for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Aquatic Therapy does not seem appropriate as the patient has received land-based Physical therapy. There is no records indicating intolerance of treatment, incapable of making same gains with land-based program nor is there any medical diagnosis or indication to require Aqua therapy at this time. The patient is not status-post recent lumbar or knee surgery nor is there diagnosis of morbid obesity requiring gentle aquatic rehabilitation with passive modalities and should have the knowledge to continue with functional improvement with a Home exercise program. The patient has completed formal sessions of PT and there is nothing submitted to indicate functional improvement from treatment already rendered. There is no report of new acute injuries that would require a change in the functional restoration program. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this injury. Per Guidelines, physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. Submitted reports have not adequately demonstrated the indication to support for the pool therapy. The Aquatic therapy two (2) times per week for four (4) weeks for the lumbar spine is not medically necessary and appropriate.

**Home interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage,

increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with return to work and exercises not demonstrated here. Submitted reports have not adequately demonstrated functional improvement derived from Transcutaneous Electrotherapy previously rendered. The Home interferential unit is not medically necessary and appropriate.

**Norco 10/325mg (hydrocod/apap 10/325mg) 1 po QD prn pain #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

**Decision rationale:** Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Norco 10/325mg (hydrocod/apap 10/325mg) 1 po QD prn pain #30 is not medically necessary and appropriate.